Medicare Program Integrity Manual

Chapter 12 – Carrier, DMERC, FI and Full PSC Interaction with the Comprehensive Error Rate Testing Contractor

Table of Contents
(Rev. 115, 07-22-05)

12.3 - Comprehensive Error Rate Testing (CERT) Program Safeguard Contractor (PSC)
(Rev. 71, 04-09-04)

CMS has developed the CERT program to produce national, contractor's specific, and service-specific paid claim error rates. The program has independent reviewers periodically review representative random samples of Medicare claims that are identified as soon as they are accepted into the claims processing system at Medicare contractors. The independent reviewers medically review claims that are paid and claims that are denied to ensure that the decision was appropriate.

The outcomes are a provider compliance error rate, paid claims error rate, and a claims processing error rate.

The CERT contractor is responsible for operating the CERT Operations Center and for gathering information from Medicare contractors. For the purpose of this section of the manual, the term "affiliated contractor" (or AC) shall be used to refer to carriers, DMERCS, and FIs. The term "full PSC" shall be used to refer to any PSC tasked with prepayment medical review responsibilities.

12.3.1 - Affiliated Contractor (AC)/ Full PSC Communication with the CERT Contractor
(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

For the purposes of this chapter, the term "AC" refers to each contractor number for which CERT produces an error rate. For example, while CIGNA may be one corporation, they are 3 separate AC's.

A. CERT Staff

When AC's/full PSC's have questions regarding the CERT program or need to contact the CERT contractor, they should contact:

AdvanceMed
CERT Review Contractor
1530 E. Parham Road
Richmond, Virginia 23228

Phone: (804) 264-1778
Fax: (804) 264-3268

Livanta
CERT Documentation Contractor
Suite 9
9090 Junction Drive
Annapolis Junction, MD 20701

Phone: (301) 957-2380
Fax: (240) 568-6131

B. AC/Full PSC CERT Points of Contact (POC)

The AC's must provide the CERT contractor with the name, phone number, address, fax number, and e-mail address of two points of contact (POC): *a general POC and an IT POC.* The CERT contractor will contact the AC's IT POC to handle issues involving the

exchange of electronic data. The CERT contractor will contact the AC's *general POC* to handle issues involving exchange of information in written form or through discussion (e.g., error reports on payment determinations, discussions on medical review decisions, status of overpayment collections, *and* status of appeals).

Beginning in 2005 AC's must keep all contact information current in the Point of Contact (POC) directory on the CERT confidential Web site. The POC Directory will contain name, e-mail, phone number, contractor affiliation, etc. to reference contact information and generate e-mail lists for CERT correspondences. At a minimum, one person from each AC will be designated as a "contractor administrator" and will be responsible for keeping the list of contacts from his/her specific contractor current. The contractor administrator(s) will also be responsible for giving access (username and initial password) to new points of contact. Each POC is responsible for updating his/her contact information. Help with the directory can be found in the POC Directory user guide or by contacting CERT@nerdvana.fu.com.

C. Applications to Assist Communication

A number of applications have been developed to foster the communication and exchange of information between the CERT contractor, AC's, and CMS. Several applications include:

- CERT Confidential Web site provides access to:
    - *The CERT Process Resources (i.e., Frequently Asked Questions, CERT Review Manual, CERT Review Schedules, Cluster Lists),*
    - *CERT Reports,*
    - *Error Rate Reduction Plans, and*
    - *Error Rate Data.*

To apply for access to the CERT Confidential Web site, e-mail the Fu contractor at *CERT@nerdvana.fu.com.*

- Secure e-mail allows:
    - AC's/full PSC's to send and receive privacy-protected information (i.e. beneficiary names and HIC numbers) over a secure e-mail system.

To obtain an application for secure e-mail, e-mail SECMAL@cms.hhs.gov.

- CERT Claims Status Web site displays:
    - Non-Response rate for each contractor/cluster
    - Tardy and missing documentation list about providers (implemented 2/15/04)
    - Overpayment and Appeals Tracking System

- Status of all claims in the final sample
- *Feedback file information and history*
- *Tech Stop claims*

To apply for access to the CERT Claims Status Web site, e-mail *Sheri Burlew at BurlewS@psccert.org.*

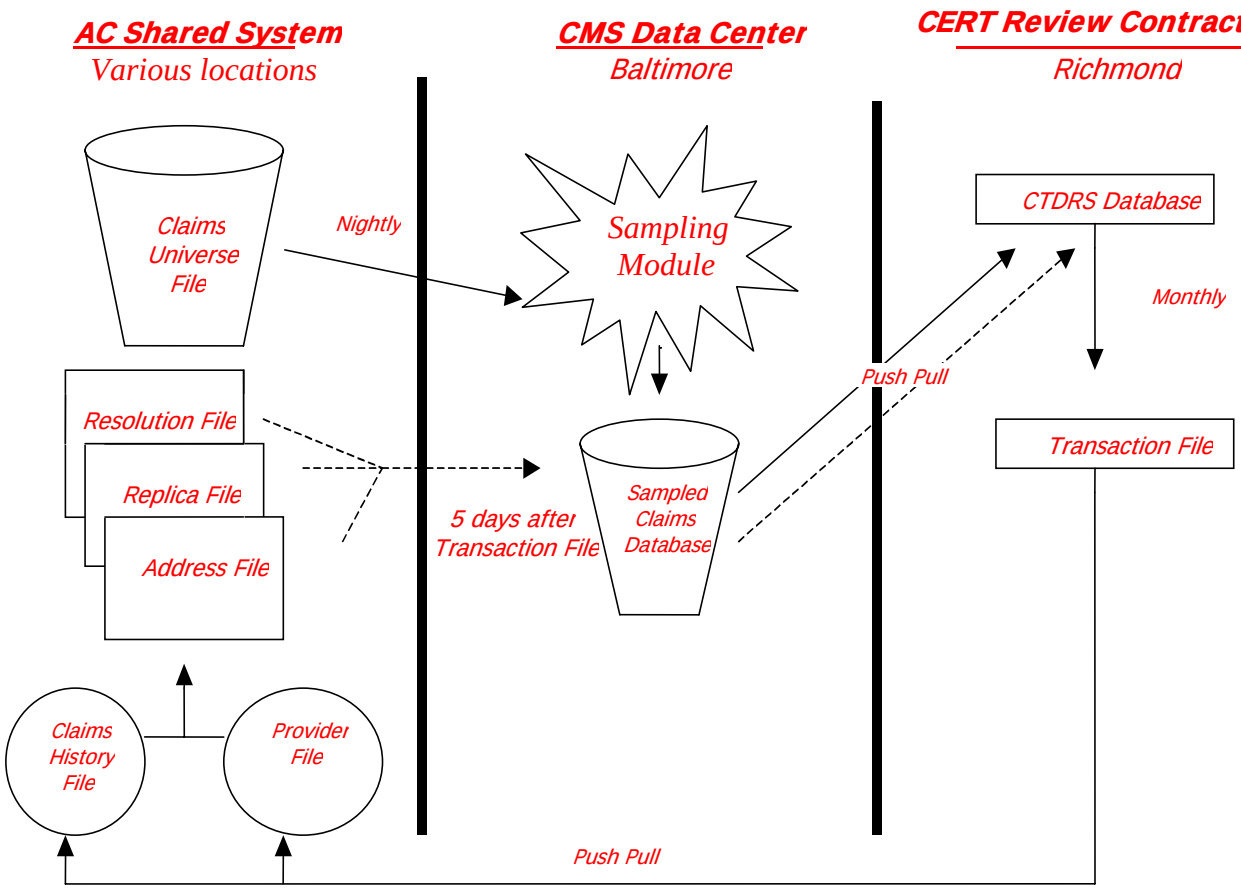
12.3.2 - Overview of the CERT Process

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

The CERT process begins at the AC processing site where claims that have entered the standard claims processing system on a given day are extracted to create a Claims Universe File. This file is transmitted each day to the CERT Operations Center, where it is routed through a random sampling process. Claims that are selected as part of the sample are downloaded to the Sampled Claims Database. This database holds all sampled claims from all AC's. Periodically, sampled claim key data are extracted from the Sampled Claims Database to create a Sampled Claims Transaction File. This file is transmitted back to the AC and matched to the AC's' claims history and provider files. A Sampled Claims Resolution File, a Claims History Replica File, and a Provider Address file are created automatically by the AC and transmitted to the CERT Operations Center. They are used to update the Sampled Claims database with claim resolutions and provider addresses; the Claims History Replica records are added to a database for future analysis.

Software applications at the CERT Operations Center are used to review, track, and report on the sampled claims. Periodically, the CERT contractor requests the AC or full PSC to provide information supporting decisions on denied/reduced claims or claim line items and claims that have been subject to their medical review processes. The CERT contractor also sends reports identifying incorrect claim payment to the appropriate AC or full PSC for follow-up. AC's/full PSC's then report on their agreement and disagreement with CERT decisions, status of overpayment collections, and status of claims that go through the appeals process.

Below is a graphical representation of the CERT sampling process


AC Shared System
Various locations
CMS Data Center
Baltimore
CERT Review Contractor
Richmond
Claims Universe File
Nightly
Sampling Module
CTDRS Database
Monthly
Push Pull
Resolution File
Replica File
Address File
5 days after Transaction File
Sampled Claims Database
Transaction File
Claims History File
Provider File
Push Pull

12.3.3 – AC/Full PSC Requirements Surrounding CERT Reviews
(Rev. 71, 04-09-04)

ACs/full PSCs must supply the CERT contractor with the sample claims resolution file within five working days of receipt of the CERT request. This request is called the sampled claims transaction file. The AC/full PSC must enter the indicator data to allow the shared systems to identify each line of service the contractor subjects to complex manual medical review or routine manual medical review. If the CERT contractor requests claim information in the sampled claims transaction file, and receives no automated resolution file from the AC/full PSC, the CERT contractor will score the claim as an error and notify the AC/full PSC's CERT POC.

12.3.3.1 - Providing Sample Information to the CERT Contractor
(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

Requests for claim information will be transmitted in the format specified in the sampled claims transaction file section of Exhibits 34.1 (carriers and DMERCs) and 34.2 (FIs and RHHIs). The AC's response must be made using NDM and the formats provided for the sampled claims resolution file in Exhibit 34.1 (carriers and DMERCs) and 34.2 (FIs and RHHIs). Full PSC's are not responsible for this task.

The AC's/full PSC's must coordinate with the CERT contractor to provide the requested information for claims identified in the sample in an electronic format. The sampling module will reside on a server in the CMS Data Center (CMSDC).

The AC's/full PSC's must submit a file daily to the CERT contractor (via CONNECT:Direct) containing information on claims entered during the day. Estimated claim volume is 2000 claims/cluster/year.

The AC's/full PSC's must respond to the CERT contractor within five working days of receipt of the request from the CERT contractor. *In the spring of 2005, the CERT program will begin moving to daily transaction files. Contractors receiving daily transaction files shall send daily resolution files, to decreasing the time lag between claim submission and error rate scoring.* If the AC/full PSC receives a request for a claim that is no longer in the system or a claim that needed to be replaced, the AC/full PSC must provide a legitimate reason and send appropriate documents to the CERT contractor. In the case that a claim is requested for a patient that does not exist, the AC/full PSC should contact the provider. For all other requests, the AC/full PSC will provide the following three files to the CERT contractor:

A. Claims Universe File

The standard systems will create a mechanism for the data centers to be able to create the claims universe file, which will be transmitted daily to the CMSDC. The file will be processed through a sampling module residing on the server at CMSDC. FIs and RHHIs, must insure that the claims universe file contains all claims, except HHA RAP claims,

adjustments, and inpatient hospital PPS claims, that have entered the FI and RHHI standard claims processing system on any given day. Carriers and DMERCs must insure that the claims universe file contains all claims from their claims processing system on any given day. Any claim must be included only once and only on the day that it enters the system.

B. Sampled Claims Transaction File, Sampled Claims Resolution File and Claims History Replica File

The standard systems will create a mechanism for the data centers to be able to periodically receive a sampled claims transaction file from the CMSDC. This file will include claims that were sampled from the daily claims universe files. The standard systems will create a mechanism for the data centers to be able to match the sampled claims transaction file against the standard system claims history file to create a sampled claims resolution file and a claims history replica file. The claims history replica file is a dump of the standard system claims history file in the standard system format. *These files shall be transmitted at the same time to the CMSDC.* The resolution file is input to the CERT claim resolution process and the claims history replica file is added to the Claims History Replica database.

If a claim identified on the transaction file is not found on the standard system claims history file, no record should be created for that claim. These are called 'no resolution' claims. Since the CERT contractor counts most 'no resolution' claims as errors (for the provider compliance error rate and the services processed error rate), the AC shall take all necessary steps to minimize the number of 'no resolution' claims it submits to the CERT contractor each year. Should the AC submit a 'no resolution' claim to the CERT contractor and later locates the needed resolution information; the AC shall provide the late resolution information to the CERT contractor. AC's can obtain a list of 'no resolution' claims they submitted for a given time period by accessing the Outstanding Documentation Requests report on the Claims Status Web site.

Some 'no resolution' claims will not be counted as errors: those with acceptable no resolution reasons. Exhibit 34.8 contains a list of acceptable no resolution reasons. Should the AC discover that one or more of their 'no resolution' claims has an acceptable reason, the AC shall notify Debby Blessing:

- At Blessind@dynpsc.org, if the communication does not include a HICN, or
- via secure e-mail or fax (443) 436-9413, if a HICN is included and the CERT contractor will send the revised claim record in the next month's transaction file.

The AC/full PSC must keep documentation on file that supports the 'no resolution' acceptable reason. The AC/full PSC must make this documentation available to CMS or OIG upon request. It is important that if the claim number changes within the standard system as a result of adjustments, replicates, or other actions taken by the AC, that the sampled claims resolution file(s) and claims history replica file(s) be provided for each

iteration of the claim (e.g., that adjustments and other actions be contained in the transmitted files). The sampled claims transaction file will always contain the claim control number of the original claim.

See Exhibit 34.2 for format of the sampled claims resolution file.

Contractors are responsible for correcting and resubmitting these files, if the CERT contractor discovers any mistakes or inaccurate data on previous submissions.

C. Provider Address File

The AC's must transmit the names, addresses, and telephone numbers of the billing providers and attending physicians in a separate file to the CMSDC along with the sampled claims resolution file. When submitting the address file to the CERT contractor, AC's should choose to produce a text file of the addresses. *The provider address file must contain the mailing and telephone contact information for each billing provider and attending physician on the sampled claims resolution file for all claims. Each unique provider name, address, and telephone number must be included only once on the provider address file. In the future, if a billing provider/attending physician has more than one address listed in the AC files, the AC shall include one record for each address in the provider address file. If the AC has neither an address nor a telephone number for the billing provider/attending physician, then the AC must not include a record for that provider in a provider address file. If the contractor has only partial information on a provider, e.g., a telephone number but no address, the AC should include on the provider address file the information the AC has and leave the rest of the fields on the record blank. AC's may (but are not required to) compare the addresses they send to the CERT contractor in the Provider Address File with the AC's provider enrollment unit's files that may list "location of medical records". To view the address CERT has for a given provider, the AC should go to the Outstanding Documentation Requests report on the CERT Claims Status Web site, and click on the CID number associated with that provider. Should the AC want the CERT contractor to send the documentation request letter to a new/updated address, the AC shall follow the instructions listed in PIM, 12.3.10.D.*

Exhibit 34.1 lists the assumptions and constraints associated with these three files.

In the case of a full PSC, it is the claims processing contractor that is responsible for providing sample information to the CERT contractors.

For work performed in Fiscal Year (FY) 2004, the functional area that is performing these activities should capture costs and workloads associated with providing sample information to the CERT contractor. Beginning with work performed in FY 2005, AC's must allocate all the costs and workloads associated with §12.3.3.1 to the PM CERT Support code (12901). AC's/full PSC's must use MR staff in concert with staff from other units to supply provider addresses to the CERT contractor. AC's/full PSC's may choose which staff to use in performing all other activities in §12.3.3.1. In the case of the

full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

D. Canceling Claims

Should an AC/full PSC or provider cancel/void/delete a sampled claim, it may or may not count as an error depending on 1) whether the cancellation/void/deletion occurs before or after the CERT Review Contractor sends the sends the transaction file to the AC/Full-PSC; 2) whether the AC/full PSC notifies the CERT contractor of an acceptable reason for canceling/voiding/deleting the claim; and 3) whether the AC/full PSC paid or denied the claim.

The chart below describes the circumstances under which the CERT contractor will consider a cancelled/voided/deleted claim to be an error.

	ACCEPTABLE Reason for Canceling the Claim	***UNACCEPTABLE Reason for Canceling the Claim***	
		AC paid the claim	***AC denied (full or partial)***
BEFORE the AC receives the Transaction File	*These claims will be considered to be "OK":* - *Not a paid claim error* - *Not a provider error* *CERT will score as follows:* - *Paid: $0/$0* - *Provider: $0/$0*	*These claims will be considered to be all 3 errors:* - *Is a paid claim error* - *Is a provider error* *CERT will score as follows:* - *Paid: $x/$x* - *Provider: $x/$x*	*These claims will be considered to be the following errors:* - *NOT a paid claim error* - *Is a provider error* *CERT will score as follows:* - *Paid: $0/$0* - *Provider: $x/$x*
AFTER the AC receives the Transaction File	*CERT Contractor will review the SAMPLED version of the claim and score it according to the finding of the review.*	*Same as above*	*Same as above*

12.3.3.2 - Providing Review Information to the CERT Contractor

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

Upon request, the AC's and full PSC's must provide the CERT contractor with all applicable materials (e.g., medical records) used to deny (in-part or total) or approve a sampled claim for medical review reasons or deny a sampled claim due to claims processing procedures. Generally, AC's and full PSC's will have to supply additional materials on ten percent or less of those claims sampled.

The CERT contractor will request the additional information from the AC's. The CERT contractor will include a checklist of items required for each record in each request. The requests will be batched on a daily basis. AC's/full PSC's shall return the requested information to the CERT Operations Center at the address specified in section 3.2 above ("Affiliated Contractor (AC)/ full PSC Communication with the CERT contractor"). AC's/full PSC's must send this material within ten (10) working days of receipt of the CERT request. Those AC's that capture and store imaged medical records from providers via fax and those AC's who scan paper medical records from providers should contact the CERT contractor to arrange for the transfer of the imaged record.

In the case of the full PSC, it is the full PSC who is responsible for providing review information to the CERT contractor.

For work performed in FY 2004, the functional area that is performing these activities should capture costs and workloads associated with pulling medical records, photocopying medical records, and mailing medical records to the CERT contractors. Beginning with work performed in FY 2005, AC's must allocate all costs and workloads associated with pulling medical records, photocopying medical records, and mailing medical records to the CERT contractor to the MIP CERT Support code 21901. No supplemental budget requests (SBRs) will be considered for this work. AC's/full PSC's shall use MR staff in concert with staff from other units to perform the activities listed in §12.3.3.2. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.3.3 - Providing Feedback Information to the CERT Contractor

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

Requests for Feedback Information

- *Twice each month, the CERT contractor will send a description of errors it has found to each AC/full PSC. AC's/full PSC's will use the CERT feedback file to provide feedback to the CERT contractor. In the case of the full PSC, the CERT contractor will send the feedback file to the full PSC, who will coordinate with its AC to complete all fields*.

- Effective March 1, 2004, the CERT contractor no longer has to communicate non-response errors to the AC/full PSC on a monthly basis. Instead, every July 23rd, the CERT contractor will provide each AC/full PSC with a list of non-response errors that occurred during the current November report period.

- *In the future (summer 2005 or later) an electronic copy of every medical record involved in an overpayment or underpayment situation will be made available to the AC. In the interim, if the AC/full PSC needs a copy of a medical record found to be in error in order to conduct further analysis, the AC/full PSC may request the medical record by sending a fax to Michele Brown at 804-264-9764.*

Sending Feedback Information to the CERT Contractor

- The AC's/ full PSC's must provide the CERT contractor with the requested feedback in accordance with the following schedules:

  For special error code 99 feedback files received in April and September

  - *The AC shall return the feedback file within seven business days for every 30 claims that are anything other than no-documentation lines.*

  - The AC shall return the feedback file including the *no documentation lines* (error codes 15, 16, and 41) within 30 working days. AC's/full PSC's will not have to separate non-response lines from denied lines. The CERT contractor shall send separate feedback files.

  - *If the CERT contractor has not received documentation by the day after the end of the AC's response period, the CERT contractor will score the relevant claims as errors.*

  - *The AC/full PSC may NOT leave a feedback line blank. A blank line will be scored as an error.*

  For all other feedback files

  - *If the AC is providing an ESTIMATED "contractor recalculated final amount paid", the AC shall return the feedback file within seven business days for every 30 claims*

  - *If the AC is providing an EXACT "contractor recalculated final amount paid", the AC shall return the feedback file within 25 working days.*

  - *AC's/full PSC's may have portions of the feedback tool blank if CWF fails to produce a new price in a timely manner. The AC/full PSC may also leave a feedback line blank by choice. In both cases, uncompleted claims will be returned to the AC in the following month's feedback file.*

- *The AC's/ full PSC's must provide answers to the CERT contractor on the status of claims that the CERT contractor identified in the sample, but for which there is no indication the AC has adjudicated the claim. These claims will not be included on the feedback files because the CERT contractor does not have documentation to review. The CERT contractor will request the status of these claims by sending the AC/full PSC a letter. The letter will list both the claims in the sample that the CERT contractor received and a list of claims that are missing. The AC/ full PSC shall clarify and coordinate with the CERT contractor on issues arising as part of the CERT project.*

- In situations where the CERT contractor sends feedback information to the AC/full PSC indicating that a claim must be denied due to the providers failure to submit requested documentation, and the provider later sends in the medical records for that same claim, the CERT contractor will state on the next feedback file that the claim was denied due to lack of documentation and after reviewing the medical records, the claim is fully or partially denied due to another reason. In these situations the AC/full PSC shall enter the same dollar amounts (i.e., same final calculated amount, etc.). See section *12.*3.4-Handling Overpayment and Underpayments Resulting from the CERT Findings for how to notify the provider about changed denial reasons.

- *The AC/ full PSC may request a meeting with the CERT contractor to discuss the results of the CERT review. During these meetings the AC/ full PSC shall ensure that the CERT contractor has considered all information available for review.*

- *Feedback information shall not include the beneficiary name or the HIC number.*

Repricing

In the case of RUGs, HRG, APCs, and other bundled payment groups, the AC/full PSC must determine *whether* the error affect*s* the payment amount. In cases where the error does not affect payment, the AC/full PSC shall notify the CERT contractor so that the CERT contractor can "back out" the error. *Backing out errors entails changing the status of a claim from error to non-error or error to partial error.*

The first step AC's/full PSC's should follow when reviewing a claim is to calculate the amount in error and then notify CERT via the feedback report (see 3.6.5). If an AC/full PSC knows the amount in error by looking at the face of the claim, (e.g. a full denial) enter the amount in error and return the feedback file to the CERT contractor. If the AC/full PSC cannot tell the amount in error from the face of the claim, (e.g. a partial denial) enter the claim data into the "adjustment" system, which will calculate the amount in error for the AC/full PSC. Then return the feedback file to the CERT contractor.

Carriers, DMERCs, and full PSC's shall take special care to list accurate information into the final allowed amount field. AC's/full PSC's must enter into this field the amount that would be allowed for the line (i.e. paid amount + coinsurance + deductibles + offsets) if the claim were paid at the level indicated after CERT review.

The FIs shall report "Recalculated Final Allowed Amounts" as the output from their pricer. The pricer system automatically adds the outlier payments into this output. Therefore the FIs should not add or remove the payment amount listed in Value Code 17 (Outlier Payments).

APASS users input the adjustment into the system. The AC/full PSC might have an overpayment. *In which case, once* the overpayment amount has been calculated, the AC/full PSC *shall* enter this number into the feedback file. If this amount is lower than

the threshold required for collecting the overpayment, the AC/full PSC must delete the adjustment from the system. FISS users follow the same procedure except if the amount *of overpayment is lower than the threshold required for collecting the overpayment*, then the AC/full PSC must inactivate the adjustment in the system.

In the case of the full PSC, it is the full PSC who is responsible for providing feedback information to the CERT contractor.

For work performed in FY 2004, the functional area that is performing these activities should capture costs and workloads associated with the CERT feedback process (including but not limited to: CMD discussions about CERT findings, biweekly CERT conference calls, and time spent responding to inquiries from the CERT contractor). Beginning with all work performed in FY 2005, AC's must allocate all costs and workloads associated with §12.3.3.3 activities to the MIP CERT Support code (21901). No Supplemental Budget Requests (SBRs) will be considered for this work. AC's/full PSC's shall use MR staff in concert with staff from other units to provide feedback reports. AC's/full PSC's shall use non-MR staff to provide an estimated contractor recalculated final amounts paid. AC's/full PSC's may use MR or non-MR staff when determining whether errors affect payment in RUG, HRG, APC and other bundled payment cases. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.3.3.1 - Disputing/Disagreeing with a CERT Decision

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

Disputes

For each 'dispute' *that the CERT contractor cannot resolve*, the CERT contractor will forward the file for the line to the CMS Central Office Clinical Panel ('CO Panel'). The CO Panel will have 20 working days to complete its review and render a determination on the line. The CERT contractor will notify the AC of the results *within 10 days* after the CO Panel has made their dispute decision. Each contractor/full PSC will be allowed to file up to one dispute of *any line type per quarter*. (i.e., a cluster with three contractors may dispute three lines). The AC/full PSC must *decide which lines to* dispute with each feedback file *by the day the feedback is due* (i.e., If the AC/full PSC receives the feedback file on April 23, 2004 and they choose to dispute line with this feedback file, they cannot dispute lines on the May or June feedback file.). The disputing contractor must provide sufficient written evidence to support their dispute upon submission. If such supporting evidence is lacking, the CO panel will uphold the CERT *contractor's* decision. Should the AC/full PSC elect not to submit a dispute in a given quarter, the unused opportunity does not carry over to the following quarter, rather the opportunity to dispute is lost for the quarter in question.

Disagrees

If the AC/full PSC does not agree with a CERT decision, but the AC/ full PSC does not choose to 'dispute' the claim, then the AC/ full PSC may mark the case as a 'disagree' in the feedback file, and include an explanation of their rationale. CMS will review these disagrees on a monthly basis. CMS will notify the CERT contractor who will report CMS findings to the AC/full PSC. CMS will respond only to disagrees that provide an explanation with supporting evidence.

In the case of the full PSC, it is the full PSC who is responsible for disputing and disagreeing with CERT decisions.

For work performed in FY 2004, the functional area that is performing these activities should capture costs and workloads associated with the CERT feedback process (including but not limited to: CMD discussions about CERT findings, biweekly CERT conference calls, and time spent responding to inquiries from the CERT contractor). Beginning with all work performed in FY 2005, AC's must allocate all cost and workloads associated with §12.3.3.3.1 activities to the MIP CERT Support code (21901). No Supplemental Budget Requests (SBRs) will be considered for this work. AC's/full PSC's shall use MR staff in concert with staff from other units to provide feedback reports. AC's/full PSC's shall use non-MR staff to provide an estimated contractor recalculated final amounts paid. AC's/full PSC's may use MR or non-MR staff when determining whether errors affect payment in RUG, HRG, APC and other bundled payment cases. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.4 - Handling Overpayments and Underpayments Resulting From the CERT Findings

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

The instructions in this section apply only to overpayments and underpayments that result from CERT findings. AC's shall continue to handle overpayments and underpayments resulting from non-CERT findings as instructed in other manuals.

If the feedback file indicates that an overpayment was made when the AC/full PSC made its original decision on the claim, the AC shall undertake appropriate collection (or payment) actions. The FI may list the adjustment indicator as 'HCFA' until such time as a CERT indicator exists. FIs should fill in the bill type ('xxH') such that the first and second positions describe the bill type and the third position is H, which indicates there were adjustments due to CERT. If the AC/full PSC has the ability to create a denial code, they should create a "CERT initiated denial" denial code. AC's/full PSC's shall not make overpayment/underpayment adjustments on zero dollar errors, unless the AC/full PSC is contacting the provider to notify them of a new denial reason.

AC's have the option of sending demand letters prior to receipt of feedback disks. The CERT contractor notifies AC's/full PSC's of all errors except non-response errors on a monthly basis, but notifies AC's/full PSC's of non-response errors only twice a year. Should an AC/full PSC wish to send a demand letter to a non-responder prior to receipt

of the non-responder feedback disk, they may. AC's/full PSC's are not required to do so. Should the AC/full PSC decide to send non-responder letters prior to receipt of the feedback disk, they may do so only after checking the Discards and Errors Web page, the Outstanding Documentation Web page, and ensuring that 90 days have past since the initial letter requesting medical records was issued.

For inpatient or outpatient services, Part B should follow overpayment collection procedures in Pub 100-4 Claims Processing Chapter 1, 130.4.1. Overpayment collection procedures for inpatient services can be found in Pub 100-4 Claims Processing 3, 50.

In situations where the CERT contractor receives medical records for a claim that was previously scored as an error due to non-response, and after reviewing the records the CERT contractor concludes it is a full denial or partially denied due to a different reason, the AC/full PSC must notify the provider of the changed denial reason.

The AC's/full PSC's shall not collect overpayments or pay underpayments *in cases where the beneficiary is liable. A "beneficiary-liable" claim is one in which the beneficiary, not the provider, owes the overpayment to Medicare or is owed the underpayment from Medicare. CMS's goal is to minimize the impact of the CERT program on beneficiaries. Thus, to the extent possible, contractors should not attempt to collect overpayments from beneficiaries on CERT initiated denials or attempts to pay underpayments to beneficiaries. These claims will continue to count as errors but, if possible, the AC/full-PSC should arrange to have the monies uncollected/unrepaid. Beneficiary-liable claims may occur in the following situations:*

1. *The service has no benefit category.*
2. *The service is statutorily excluded.*
3. *The service is not reasonable and necessary and the beneficiary has signed an ABN.*
4. *Unassigned Claims (carriers/DMERCs only).*

In situations where an AC's shared systems is set up to automatically collect from or send money to the beneficiary the AC should seek a manual workaround. Where no manual workaround is possible, the AC shall collect the overpayment from or repay the underpayment to the beneficiary.

In the case of a full PSC, it is the claims processing contractor that will handle overpayment/underpayment actions.

If the AC/full PSC requires more information about the reason for the overpayment/underpayment than is available in the feedback file, the AC/full PSC may contact Ellen Cartwright, the CERT contractor MR manager, at (804) 264 – 1778 ext. 106.

The AC shall collect overpayments detected by the CERT program. Effective 30 days from the date of the transmittal, the AC shall make every effort to either:

1. *Pay the provider the full amount due on underpayments detected by the CERT program, or*
2. *Pay the provider the submitted charge amount and educate the provider about future billing amounts.*

EXAMPLE 1:

- *The provider submits a claim for Level 2 service with a billed amount of **$50**.*
- *The AC pays the claim without review at the fee-schedule amount for a Level 2 service, $20.*
- *The CERT program samples the claim, reviews the medical record and determines that the provider performed a Level 3 service with a fee-schedule amount of $30. The CERT contractor communicates this to the AC via the feedback process.*
- *The AC shall pay the provider the difference between the fee-schedule amount for the service billed and the fee-schedule amount for the correctly coded service or, in this case, $10.*

EXAMPLE 2:

- *The provider submits a claim for Level 2 service with a billed amount of **$25**.*
- *The AC pays the claim without review at the fee-schedule amount for a Level 2 service, $20.*
- *The CERT program samples the claim, reviews the medical record and determines that the provider performed a Level 3 service with a fee-schedule amount of $30. The CERT contractor communicates this to the AC via the feedback process.*
- *The AC may either:*

    1. *Pay the provider the difference between the fee-schedule amount for the service billed and the fee-schedule amount for the correctly coded service, or*
    2. *Pay the provider the difference between the paid amount and the submitted charge. If this option is included the AC shall educate the provider about billing the proper amounts in the future.*

For work performed in FY 2004, AC's must allocate the costs and workloads associated with handling over/underpayments resulting from CERT findings as they do all other over/underpayments. Beginning with work performed in FY 2005, AC's must allocate all costs and workloads associated with §12.3.4 activities to the PM CERT Support code (12901). AC's/full PSC's shall use claims processing staff to perform these activities. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.5 - Handling Appeals Resulting From CERT Initiated Denials

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

The AC's shall process appeals stemming from the CERT project (e.g., CERT decisions appealed by providers or beneficiaries). AC's must not automatically uphold the CERT contractor's decision. Instead, the AC's shall insure that the appeal is handled in the normal way (i.e. reviewed by a different reviewer, etc.). See Exhibit 34.12 Fee-For-Service Appeal Processes.

In the case of the full PSC, it is the claims processing contractor that is responsible for processing appeals resulting from CERT-initiated denials.

The AC's and claims processing contractors affiliated with a full PSC *shall* send the CERT contractor medical record requests on appeals for all CERT-initiated denials on a flow basis (via fax). Even if the AC believes they have enough documentation to make a determination on the appeal, the AC *shall* still request the documentation (experience shows that providers sometimes submit different documentation to the CERT contractor than to the AC upon appeal). *If the CERT contractor fails to provide the requested medical records to the AC in a timely manner, the AC may proceed with the processing of the appeal as normal.* In the future, when the CERT *Documentation Contractor makes* an electronic copy of every medical record involved in an overpayment or underpayment *available* to the AC, the AC can then cease requesting medical records from the CERT *Documentation Contractor* upon provider appeal. *Instead, the AC will be able to view the imaged medical record via a browser over MDCN lines using IBM's e-client software.*

Contractors may temporarily suspend reason codes that prevent the adjustment of a CERT-initiated denial claim that will not process due to the age of the claim. The suspension shall only last long enough for the claim to be adjusted. (Example: reason code 36200 was not in effect when the initial claim processed. The CERT contractor has now reviewed the claim and determined that it should be adjusted. The claim will not process because this edit cannot be overridden.)

For work performed in FY 2004, AC's must allocate the costs and workloads associated with handling appeals of CERT initiated denials as they do all other appeals. Beginning with performed in FY 2005, AC's must allocate all costs and workloads associated with §12.3.5 activities to the PM CERT Support code (12901). AC's/full PSC's shall use appeal staff to perform these activities. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.6 – Tracking Overpayments and Appeals

(Rev. 77, 05-28-04)

12.3.6.1 - Tracking Overpayments

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

Upon request, the AC must provide the CERT contractor with the status and amounts of completed overpayment collections (or underpayments that have been paid). 'Completed Overpayment Collections' means that the overpayment amount has been fully collected or the AC has *failed to recoup the overpayment amount from the provider in a specified time and has* and referred the debt to Treasury or another entity. *The overpayment is not collected when the claim has been adjusted and the accounts receivable set up. The overpayment is collected when the provider sends in the overpayment check [or other payment arrangement has been completed] or when the full amount of the overpayments has been collected via offset.*

EXAMPLE: On day 15, the CERT contractor notifies the AC of an $800 overpayment via the feedback file process for CID # 12345. On day 20, the AC establishes an 'accounts receivable' in its overpayment tracking system. On February 1, the CERT contractor requests an update on all Completed Overpayment Collections. The AC shall not include any information about CID # 12345 in the response since the overpayment collection action has not yet been completed. On February 15, the provider notifies the AC that they would like to payback the overpayment via $200 offsets per month for the next 4 months. The AC sets the offsets in their system on February 20. On March 1, the CERT contractor requests an update on all completed overpayment collections. The AC shall not include any information about CID # 12345 in its response since overpayment collection action has not yet been completed. On May 20, the AC offsets the final $200 from the provider. On June 1, the CERT contractor requests an update. The AC shall inform the CERT contractor that for CID # 12345, the overpayment collection action *was completed* on May 20.

Beginning in the spring of 2005, the CERT contractor will *post a list for* each AC of claims that are overpayments and subject to appeal. This *list will be located on the CERT claims status Web site.*

For FY 2004, the functional area that is performing these activities should capture costs and workloads associated with tracking and reporting overpayment/underpayment information to the CERT contractor. Beginning with work performed in FY 2005, AC's shall allocate all costs and workloads associated with §12.3.6.1 activities to the PM CERT Support code (12901). In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.6.2 - Tracking Appeals

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

Appeal Request

Contractors may enter appeal requests to the claims status Web site as contractor workload permits (daily, weekly, or monthly). To speed up the review process and obtain

the most accurate error rate information, contractors should upload appeals of CERT initiated denials to the Claims Status Web site as they occur.

Which Appeals Affect the Error Rates

If the AC appeal process includes a review of the medical records submitted by the provider with the appeal, the AC must notify the CERT contractor about each appeal of a CERT-initiated denial, including the appeal decision. *Appeals must be uploaded before the cut-off date described in the CERT review manual to have an impact on the error rate.* The CERT contractor will reflect these appeal full and partial reversals in the CERT Claims Database. *For example, if the AC notifies the CERT contractor that a provider lost an appeal (the decision was maintained or upheld), the error will not be removed from the CERT database. If the AC notifies the CERT contractor that the provider won on appeal (the original decision was fully or partially reversed), the CERT contractor will remove the error completely from the CERT database. If the AC notifies the CERT contractor that a provider partially won an appeal, the CERT contractor will remove the appropriate dollar amount as an error from the CERT database*

In the case of the full PSC, the claims processing contractor provides the CERT contractor with the status of appeals decisions with a cc: to the full PSC.

The appeal section of the Claims Status Web site will include the following information for each line/*claim* of a CERT-initiated denial appealed by the provider:

- CID#
- CCN#
- Contractor Name
- Contractor Number
- Contractor staff person's name and phone number
- From and To Dates of Service
- Medicare Final Allowed Amount *(Column G)* (final amount *originally* paid to the provider + patient responsibility *before CERT decision*)
- Appeal Decision (overturn the denial, uphold the denial in full, uphold the denial in part)
- Date of Appeal Decision
- Appeal Level (re-review, hearing officer, ALJ, QIC, DAB, etc.)
- Contractor Recalculated Final Allowed Amount as adjusted by the appeal decision *(Including patient responsibility) (Column K)*

When the CERT review contractor receives late documentation, they will check the appeals section of the CERT claims status Web site to see if the provider has filed an appeal.

- *If the provider has not appealed, the CERT contractor will review the late documentation and notify the AC of its decision. The AC shall consider this CERT notification to be a cause for re-opening the claim and paying the*

provider. If the CERT contractor's review results in an error (full or partial) the CERT contractor shall notify the AC of the new error reason. The AC shall notify the provider that the original denial has been replaced with a different denial reason. This notice gives the provider a new 120 day time frame in which to appeal the new determination.

- *If the provider has filed an appeal, the CERT review contractor will set aside the documentation and take action on the decision made by the appeal determination.*

If a provider asks whether he should submit late documentation to the CERT contractor or to the AC appeal process, the AC shall encourage the provider to submit late documentation to the CERT contractor.

For FY 2004, the functional area that is performing these activities should capture costs and workloads associated with tracking and reporting appeals information to the CERT contractor. Beginning with work performed in FY 2005, AC's shall allocate all costs and workloads associated with §12.3.6.2 activities to the PM CERT Support code (12901). In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.8 – AC/Full PSC Requirements Involving CERT Information Dissemination

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

Sharing CERT Information With the Provider Community

The AC's/full PSC's must assist the CERT contractor by disseminating information concerning CERT to the provider community. As part of the CERT process, providers are required to send documents supporting claims per the request of CERT contractors. Unfortunately, many providers do not comply. Some providers are uncooperative because they believe it is a HIPAA violation to send patient records to CERT. Others are *not familiar with the CERT* process and fail to see the importance of cooperating in a timely fashion. AC's/full PSC's should educate the provider community about the CERT program, emphasizing the importance of providers responding to the CERT contractor's requests for medical records and explaining the consequences that will incur by not cooperating with these requests, and the significance of these errors. *AC's are encouraged to contact these providers, but only after 20 days have past since the initial CERT request was made to the provider. (See Exhibit 34.3.)* Provider education is at the discretion of the AC/full PSC. Several ways to disseminate CERT information include answering/directing provider questions to the proper representative, posting articles (or this instruction) to your Web sites, *and* sending a summary of the CERT process to the provider listserv. *Should an AC receive an inquiry from a provider asking for the status of their review, the AC shall look on the Discards and Errors section of the Claims Status Web site to see whether the review has occurred. The AC may disclose the review status and the result of the review to the provider.* Each AC/full PSC specified ways that will be used to educate providers about CERT in their Error Rate Reduction Plans.

Sharing CERT Information With Medicare Contractors

The AC's/full PSC's must share relevant CERT information with Medicare contractors, to whom they have a working relationship with (i.e., AC's and BI PSC's may share information). Examples of relevant CERT information include Improper Medicare FFS Payments Report, Errors in Medicare FFS Payments Report, and other CERT data.

In the case of the full PSC, the full PSC has the responsibility of disseminating CERT information. On occasion, the full PSC may ask the AC to assist them with the dissemination of such information if there is a level of PCOM responsibility. That process would be worked out in the AC/full PSC Joint Operating Agreement.

For work performed in FY 2004, AC's must allocate costs and workloads associated with the dissemination of CERT information to LPET CAFM code 24116. Beginning with work performed in FY 2005, AC's must allocate all costs and workloads associated with §12.3.8 activities to the MIP CERT Support code (21901). No Supplemental Budget Requests (SBRs) will be considered for this work. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.9 – AC/Full PSC Error Rate Reduction Plan (ERRP)

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

*Every November, CMS will post to **www.cms.hhs.gov/cert**, the Medicare Fee-for-Service Improper Payments Report that includes various types of error rates including contractor-specific error rates. Within 30 days of CMS's posting of the long version of the report, all AC's and full PSC's must develop an Error Rate Reduction Plan. The ERRP must describe the corrective actions they plan to take in order to lower the paid claims error rate, claims processing error rate, and provider compliance error rate. This plan must describe:*

- *Reasons for error in the contractor's jurisdiction.*
- New adjustments the AC/full PSC has made or will make to its MR/LPET Strategy.
- New coordination activities under taken with other components within AC/full PSC (e.g., developing a system to route certain provider calls from the provider call center to the MR or LPET unit for resolution).
- New information being communicated to providers including the message point and the vehicle (e.g. including in post-pay denial letters the L*CD* ID# associated with the denial, issuing additional CBRs to every provider who bills the three types of service with the highest error rate).
- *Suggestions on how CMS can help reduce the error rate or improve the CERT process.*

The AC must work closely with their PSC's. The plans must specify both:

1. Corrective actions they have already put in place

2. Which new corrective actions they have planned for the future

As required by MMA 921(a), each ERRP must include a description as to how the AC/full PSC will utilize the CERT findings to develop and implement educational efforts. For AC's that are affiliated with a "full-model" PSC (where the AC has turned all MR, LPET, and BI responsibility over to a PSC), the PSC is responsible for the creation of the Error Rate Reduction Plan. The PSC will work in cooperation with the AC to obtain language regarding areas where the PSC has no authority such as non-MR/LPET actions.

In the case of an MR PSC (where the AC has only turned post pay MR and BI responsibility over to a PSC) or BI PSC (where the AC has only turned BI responsibility over to a PSC), the AC remains responsible for the development of the Error Rate Reduction Plan. The AC will work in cooperation with the PSC to obtain language regarding post pay MR, LPET, and/or BI actions.

Beginning in 2004, all AC's/full PSC's shall submit initial ERRPs and updates via the CERT confidential Web site's Error Rate Reduction Plan Data Entry system. RO Business Function Experts (BFEs), who have the responsibility of monitoring the contractor submitting the ERRP, will receive an e-mail notification of the ERRP submission from the CERT confidential Web site. The RO Divisions of Medicare Financial Management and BFEs will determine if the ERRP is reasonable to reduce the contractor's error rate. RO Divisions of Medicare Financial Management will "approve" the entire plan after all appropriate BFEs give their "approval" regarding the portion of the plan that deals with their functional area. The approval shall take place through the RO Review function in the ERRP Data Entry system.

Each quarter (January, April, July, and October), the AC/full PSC must submit an updated plan informing CMS of their progress on the Error Rate Reduction Actions described in their initial plan. Any changes to the plan should be made in the body of the plan in database and then summarized in the revision history portion of the ERRP. The updates to the ERRP are due within 30 calendar days after the end of each quarter during the fiscal year, with the exception of the first quarter's update which may be submitted no more than 45 days after the end of the first quarter.

The deadlines for submitting ERRPs are as follows:

Initial ERRP – 30 days after the release of the long report error rate information
First quarter Update – February 15
Second quarter Update – April 30
Third quarter Update – July 30
Fourth quarter Update – October 30

Clusters that have submitted ERRPs in the past may simply update/modify their existing plans for submission to the Web site. However, clusters that have not submitted ERRPs in the past must generate a new plan for submission.

When planning corrective actions for high error rate categories identified in the CERT report *or to improve the response rate*, the AC/full PSC may not take any punitive action on any individual or group. *For example, the AC/full PSC shall not place a provider on pre- or post-pay solely due to their failure to respond to CERT document requests. However, t*he AC/full PSC may perform data analysis on these categories, and based on their results, take necessary actions.

For work performed in FY 2004, the functional area that is involved in the preparation of the ERRP should capture the costs and workloads. Beginning with work performed in FY 2005, AC's must allocate all costs and workloads associated with §12.3.9 activities to the MIP CERT Support code (21901). No Supplemental Budget Requests (SBRs) will be considered for this work. AC's/full PSC's shall use MR staff in concert with staff from other units to perform these tasks. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

12.3.10 – Contacting Non-Responders

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

A. The CERT Claims Status Web site

All AC/full PSC claim identification information for providers that have not *submitted documentation* to the CERT contractor's requests will be posted on the *Outstanding Documentation section of the* CERT Claims Status Web site (www.psccert.org) on a weekly basis. Each week, the W eb site will be updated to indicate whether the requested *documentation* has been received by the CERT contractor. *When the CERT contractor receives a response from the provider, the CERT contractor removes the provider from the Outstanding Documentation Web page. However, upon further review it may be determined that the submitted materials do not constitute a medical record. For example, the submitted document may be a request for payment of photocopying charges or a letter explaining that a third party has the medical records.*

In theses cases, the CERT contractor scores the claim as an error using error code 15 (No documentation due to extenuating circumstances), 16 (Response received - improper documentation), or 41 (Services billed were not rendered). Currently, the CERT contractor lists these no documentation claims on the Discards and Errors Web page, not the Outstanding Documentation Web page; this may change in the future to provide AC's with "one stop shopping" for no documentation errors. In the meantime, AC's shall check both Web pages to determine which of their providers have not responded. If the AC notices an outstanding documentation situation and has the required information, the AC may submit the documentation to the CERT contractor.

B. Contacting Non-Responders

The documentation cut-off date for the November Report is *listed in Exhibit 2 of the CERT review manual. In preparation* for the report*, at least 30 days prior to the cut off date each* AC/full PSC:

- *Should* check the CERT Claims Status Web site at www.psccert.org

- *May choose to* contact all providers who have failed to submit medical records *for claims sampled for the next scheduled November report* and encourage them to submit the requested records to the CERT contractor (these providers are known as 'non-responders'),

- May contact any provider who has failed to submit medical records and encourage them to submit the requested records to the CERT contractor (these providers are known as 'tardy providers'), and

- Shall NOT contact any provider selected for CERT review until 20 days after the CERT contractor's initial request for a medical record.

Although AC's/full PSC's *may* contact all non-responders, AC's/full PSC's shall prioritize communications by focusing on contacting first and more frequently, those providers who submitted high dollar claims.

*When c*ontacting providers*, it is most beneficial to speak* with an individual who has access to medical records for a given provider to ensure that a letter or fax will reach the correct recipient. Thus, phone calls to providers are perceived as more effective than sending letters or faxes, while a combination of tactics would be most effective. CMS does not require that AC's*/full PSC's* use nurses to make their contacts. AC's*/full PSC's* may use any level of staff they deem appropriate to make these calls, but generally these contacts should not require the use of a clinician. AC's*/full PSC's* who choose to send letters to encourage providers shall list an AC*/full PSC's* contact name and phone number in the letter. *AC's/full PSC's are encouraged, but not required, to make multiple telephone contacts if necessary in order to get the provider to submit the requested records to the CERT contractor. AC's/full PSC's shall NOT refer persistent non-responders to the OIG.*

When contacting the provider, if they agree to submit the medical records to the CERT contractor, the AC's*/full PSC's* shall ask the provider to include the barcode sheet with the copy. If *the provider* no longer *has* the barcode sheet, the AC's*/full PSC's* shall ask the provider to write the Claim Identification Number (CID) (which the AC's*/full PSC's* shall provide them) on the top of the medical record. AC's*/full PSC's* shall inform providers that they may fax medical records to 804-864-9980. If providers wish to speak with someone at the CERT contractor, they can call 804-864-9940 to speak with a customer service representative.

The AC's/full PSC's may – but are not required – to contact third party providers and encourage them to send the needed records to the CERT contractor. AC's/full PSC's may also pursue other additional educational means to inform providers that they are non-responders and encourage them to respond.

C. Tech-Stops

AC's may contact providers when a claim is tech stopped. Tech stop claims can be found on the Tech Stop portion of the Claims Status Web site.

D. Customizing Address

During the course of contacting a non-responder, AC's/full PSC's shall verify the address of 'high volume' providers. A 'high volume' provider is one who submitted two or more claims that were selected for CERT review. Should the AC/full PSC determine that the address in the Claim Status Web site is wrong or could be improved (e.g. adding: "attn: Compliance Officer", "John Smith", or "Medical Records Unit") the AC shall notify the CERT contractor *using the provider address modification tool on the CERT documentation contractor's Web site.*

If a national chain provider requests that the home office address be listed for each of its local provider locations, the AC may make the needed changes as indicated above.

For work performed in FY 2004, AC's/full PSC's must allocate the costs and workloads associated with contacting non-responders to LPET CAFM II Code 24116. AC's/full PSC's must report in the 'Remarks' field the dollars spent and the number of providers contacted. AC's*/full PSC's* shall not spend more than 10% or $10,000 (choosing the lesser of the two) of LPET budget on workloads associated with §12.3.10 activities. Beginning with work performed in FY 2005, AC's must allocate all costs and workloads associated with §12.3.10 activities to the MIP CERT Support code (21901). No supplemental budget requests (SBRs) will be considered for this work. In the case of the full PSC, the full PSC must report the costs and workloads associated with these tasks into PSC ART.

E. Requesting Spanish Letters

Should the AC/full PSC determine that providing CERT documentation request letters in Spanish would assist a provider in submitting the correct medical records to the CERT contractor, the AC/full PSC may contact a CERT CSR at (804) 864-9940 and request that the provider always be sent documentation request letters in Spanish. The AC/full PSC shall identify the provider by provider number and provider name.

12.3.11 - Late Documentation *Received by the CERT Contractor*

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

If documentation is not received by the *90th* day, the CERT contractor scores the claim as an error. Any documentation received by the CERT contractor after the *90th* day is considered 'late documentation'.

- If the CERT contractor receives late documentation BEFORE the CERT contractor communicates the error to the AC via the feedback process, the

CERT contractor shall review the late documentation and, if justified, revise each rate throughout the November report, May report, or updated data deliverable. If upon reviewing the late documentation the CERT contractor finds an error, it is the AC/full PSC's responsibility to notify the provider of the change in denial reasons. CMS has left the task of notifying the provider of a change in denial reasons at the AC's/full PSC's discretion. *In addition to the normal notifications sent to AC's from the CERT contractors, the AC's should periodically check the Claims Status Web site to look for changes in the status of CERT sampled claims and take appropriate action. If it had been deny and now it is OK, make a claims adjustment. If a claim had been a non-response error and now it is a medical necessity error, the AC shall issue a revised denial notice.*

- If the CERT contractor receives late documentation AFTER the CERT contractor communicates the error to the AC via the feedback process, the CERT contractor shall check with the AC to see if the provider has appealed the denial.

    - If the provider appeals the CERT-initiated denial, the CERT contractor will not review the late documentation. The AC shall communicate the results of its appeal review to the CERT contractor. If a demand letter for overpayment was sent and payment recouped the AC/full PSC is responsible for making the adjustment (i.e., pay the provider the amount he/she was due).

    - If the provider has not submitted an appeal, the CERT contractor shall review the late documentation and if justified, revise the error in each rate throughout the November report, May report, or updated data deliverable. The CERT contractor shall notify the AC of the revised decision.

12.3.12 - Voluntary Refunds

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

If the AC receives a voluntary refund from a provider on a claim in the CERT sample, the AC shall process the refund as they do all other voluntary refunds (i.e., in accordance with *the* PIM, Ch. 3, §12.8.4 and §12.8.4.1).

- *If the AC processes the voluntary refund BEFORE receiving the transaction file containing the claim in question, the AC shall notify the CERT contractor immediately.*

- If the AC processes the voluntary refund AFTER receiving the transaction file containing the claim in question, the AC should not notify the CERT

contractor. The AC shall complete the feedback file as though the voluntary refund had not been received.

12.3.13 - *Local Coverage Determinations (LCD)/ National Coverage Determination (NCD)*

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

The AC's/full PSC's shall ensure that all LCDs are made prospectively and not retroactively (unless necessitated by a National Coverage Determinations (NCD) or Coverage Provision Interpretive Manual (CPIM)).

12.4 - CERT Review Contractor Review Guidelines

(Rev. 115, Issued: 07-22-05; Effective: 08-01-05; Implementation: 08-22-05)

The CMS has directed the CERT Review Contractor to use all NCDs, LCDs, CPIMs, and national and local coverage, coding, and billing articles. In addition, CMS has directed the CERT Review Contractor to apply the following guidelines when reviewing claims.

A. E&M Services

The Evaluation and Management (E&M) services guidelines listed in the CPT code book, page 7 (2004) contains a section called "select the appropriate level of E&M services based on the following." The first sentence in this section tells providers that, "for the following categories/subcategories, all of the key components…must meet or exceed the stated requirements to qualify for a particular level of E&M service."

The AC's should be aware that CMS has directed the CERT review contractor that:

> *"In order to be correctly coded, all of the key components (ie, history, examination, and medical decision-making) must meet or exceed the requirements listed in the 1995/1997 guidelines. The term "meet or exceed" means the documentation meets or exceeds the requirements for a certain level but the requirements for the next higher level have not been met. For example, a provider bills for a Level 2 visit. The documentation exceeds the Level 2 requirements but does not meet the Level 3 requirements. The CRC shall score this case as no error. Another provider bills for a Level 2 visit while the documentation exceeds the Level 2 requirements, exceeds the Level 3 requirements but does not meet the Level 4 requirements. In this case, the CRC shall score the claim as a one level undercoding error." (CERT Manual 4.7.4.)*

B. 24 Hour Rule

The AC's should be aware that CMS has directed the CERT review contractor that:

“On occasion, a provider may submit a claim showing that the service was provided on a particular date while the medical record indicates that the service was actually provided up to 24 hours before or after the date of service on the claim. For example, the date of service listed on the claim may be for an ER visit on 1/24 while the medical record may indicate that the service was actually provided on 1/25. If a provider indicates that they do not have a medical record for the day in question (1/24) but they do have a medial record for the day before or the day afterward, the CDC or CRC CSR shall tell the provider to submit the 1/25 record in support of the 1/24 service.” (CERT Manual 3.2.1.C.)